INSURING THE UNINSURABLE: AN OVERVIEW OF STATE HIGH-RISK HEALTH INSURANCE POOLS

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EXECUTIVE SUMMARY

For many people who have no employer-sponsored health insurance but do have extensive health care needs and medical expenses, obtaining coverage in the individual insurance market is not a viable option. Premiums charged to these individuals are often unaffordable. Moreover, insurers can turn down "high risks" for coverage because of an existing or previous illness.

To help insure those who have been denied private health coverage in the individual market, more than half the states operate high-risk insurance pools. Most states also use high-risk pools to comply with provisions in the Health Insurance Portability and Accountability Act that pertain to individuals leaving employer group coverage. Some states enroll people who are eligible for Medicare in their high-risk pool for supplemental coverage. In 1999, these insurance pools covered about 105,000 people.

Using the most recently available data, this report presents a profile and analysis of high-risk pools currently in operation. The results indicate that these pools have had a limited impact in making insurance available and affordable for otherwise uninsurable individuals. Affordability as well as access are key concerns. State risk pools often charge premiums that are high relative to incomes, and typically include sizeable deductibles and copayments. Furthermore, they often restrict annual and lifetime benefits. Although designed for people with serious or chronic illnesses, risk pools tend to impose preexisting condition exclusions to reduce adverse selection, further delaying access to medical care. Some pools have long waiting lists, and some are closed to new applicants altogether.

Some of the major findings in the report include:

- Premium prices range from an average of $1,832 per year in Washington (4% of median household income) to $4,920 per year in Missouri (12% of median household income). The average premium in 29 states is $3,083 (8.1% of median household income).
- Only six states—Colorado, Connecticut, New Mexico, Oregon, Tennessee, and Wisconsin—operate income-related subsidy programs for premiums or cost-sharing requirements for eligible low-income residents.
- Deductibles are typically $500 to $1,000 but range up to $10,000 (Alaska, Arkansas, and Florida). California has no deductible.

- In addition to deductibles, most risk pools require coinsurance that amounts to 20 percent of covered expenses above the deductible. Cost-sharing rates can be even higher for out-of-network service in a plan operated by a preferred provider organization (PPO).
- Most states cap patient out-of-pocket expenses at $2,000 to $2,500 per year, but can range as high as $10,000 (Alaska, Oklahoma, and Texas) or even $20,000 in one of Arkansas's three options. Four states have no out-of-pocket limits (Colorado, Florida, Kansas, and Mississippi).
- Waiting periods for obtaining care for a preexisting condition after coverage begins are typically six months, but extend to 12 months in eight states.
- State high-risk pools typically limit coverage for mental health and maternity care. Outpatient prescriptions are usually subject to the plan deductible.
- The high-risk pools in California and Illinois have waiting lists. Florida's high-risk pool is closed to new enrollment.

As a result of costs, restrictions on benefits, and waiting periods, state high-risk pools insure an average of 1.2 percent of those covered by individual insurance—less than 2 percent in all but three states (Minnesota, Nebraska, and Oregon). Furthermore, some states cap enrollment in their pools, and most do not advertise their program. As enrollment increases, total pool losses also rise—even if average losses per person are stable.

Because all state high-risk pools operate at a loss—since medical claims paid are higher than premiums collected—states must draw additional revenues for financial support. States finance their pools through surcharges on health insurance premiums (group and individual); earmarked funds, such as "sin" taxes on tobacco products; general funds; or some combination of these three sources. Although states that draw from general funds have a more difficult time maintaining support when their budgets are tight, the use of narrowly earmarked funds are often inadequate to meet the demand for pools and do not increase with the growth in health care costs. Only limited revenues are available through state premium taxes, since the Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from paying them.

Some states have found innovative ways to broaden the revenue base that other states may wish to consider. For example, Kentucky, Oregon, Washington, and Wisconsin assess premiums of stop-loss insurers or re-insurers in addition to their traditional assessment of insurer premiums. The report notes that one way to broaden further the revenue base for pools and maintain revenue growth that is better tied to medical inflation

would be for Congress to lift ERISA's state taxation exemptions of self-insured plans for the limited purpose of high-risk pool financing.

In addition to, or instead of, reliance on high-risk pools, some states have regulated the individual market to require guaranteed issue (i.e., sell to all applicants) and to restrict the extent to which premium rates can vary based on health status and/or age. States that have implemented such reforms and maintain a high-risk pool are examples of perhaps the most promising approaches to making adequate health care coverage more available and affordable for those who are otherwise uninsurable.

INSURING THE UNINSURABLE: AN OVERVIEW OF STATE HIGH-RISK HEALTH INSURANCE POOLS

Concerned about the growing number of uninsured, many states have set up high-risk pools that provide insurance and risk-spreading functions for people who are medically uninsurable. Generally, high-risk pools allow individuals who have been denied coverage by private insurers or charged higher premiums due to their health status to obtain subsidized health insurance through the state. To make the insurance affordable, states typically cap premium rates at 125 to 200 percent of standard market rates. To make up the difference between premiums earned and claims paid, states generally provide supplemental funding. Most derive this money from taxes levied on health insurers in the state and/or by allocating general revenue or special funds.

This report describes and compares the general characteristics of 29 state high-risk pools, especially as these characteristics relate to the affordability, adequacy, and funding of coverage. We also explore tradeoffs and the relationship between high-risk pools and state regulation of the insurance market for individuals. In Sections 1 and 2, we compare eligibility rules and enrollment among state high-risk pools. Section 3 compares the premium levels of state high-risk pools. In Section 4, we analyze the benefit design of coverage in these pools, including preexisting condition exclusions, plan choice, and premium caps, as well as the significant coverage limitations some states have adopted. Section 5 examines the costs of pool programs and the different funding methods states use to close the gap between premiums earned and the pools' medical costs. We also examine low-income subsidy programs in the few states that have them. In Section 6, we examine reforms to the markets for individual health insurance that some states have adopted either in place of a high-risk pool or to complement the pool. Section 7 offers a summary and a consideration of implications for state and federal policymakers.

I. ELIGIBLE POPULATIONS

State high-risk pools in 28 states enrolled nearly 105,000 individuals in 1999 (Communicating for Agriculture (CFA) 2000).[1] Three general categories of people are eligible to enroll in most of these pools: the medically uninsurable, those eligible for guaranteed-issue individual coverage under the Health Insurance Portability and

[1] Kentucky's high-risk pool became operational January 1, 2001. As of July 1, 2002, New Hampshire will also operate a high-risk pool, having repealed guaranteed-issue individual products during the 2001 legislative session.

Accountability Act of 1996 (HIPAA),[2] and Medicare beneficiaries seeking a supplemental insurance option. Table 1 shows how eligibility rules vary in states that have high-risk pools.

The Medically Uninsurable

In most states, insurers may either deny coverage to individuals who are not members of an employer group plan and who have a past or present medical condition, or they may charge them higher prices for health insurance. Since most high-risk pools were designed to accommodate these medically uninsurable people, members of this group constitute 72 percent of pools' enrollees on average. The main exception is Alabama, which is open to HIPAA-eligibles only.

While acceptance of the medically uninsurable is one of the most common characteristics of high-risk pools, states differ on requirements for proof of uninsurability (Table 2).[3] All states accept a notice of denial due to medical reasons from a licensed health insurer as proof of being medically uninsurable;[4] six states (Florida, Kansas, Kentucky, Louisiana, Montana, and Oklahoma) require two denials. Most states also accept individuals who can obtain coverage only at premiums that exceed those of the pool. South Carolina, Louisiana, and Missouri require rate quotes higher than 150, 200, and 300 percent of pool rates, respectively (CFA 2000; Missouri Health Insurance Pool 1999). Sixteen states accept those who were offered coverage only with a restrictive rider that substantially limited covered services. Twelve states—Alaska, Colorado, Illinois, Indiana, Iowa, Kentucky, Minnesota, Mississippi, Montana, Nebraska, Texas, and Wisconsin—offer presumptive eligibility to those with a medical condition the pool has designated as not requiring proof of denial.[5] Examples of such conditions include leukemia, Hodgkin's disease, hemophilia, and AIDS.

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[2] HIPAA prohibits health insurers that offer policies to individuals from denying enrollment or imposing any preexisting condition exclusion periods for those eligible. To be HIPAA-eligible, one must have had creditable coverage for 18 months with no gaps in coverage of more than 63 full days within or after the 18-month period, and also must have exhausted any coverage available under COBRA or other state and/or federal programs. States may use a high-risk pool as an "acceptable alternative mechanism" for satisfying this requirement (CMS 1999).

[3] Since Connecticut's high-risk pool accepts all uninsured residents older than 19 and younger than 64, the program does not require the medically uninsurable to provide proof of uninsurability (CFA 2000).

[4] Despite being combined with Tennessee's Medicaid program, the medically uninsurable must provide proof of being denied individual insurance to be enrolled in TennCare. A federal judge recently ruled that private insurance companies cannot determine whether or not a person is uninsurable and therefore eligible for TennCare. The state has asked the judge to reconsider his position (Snyder 2001).

[5] Five states also have reciprocity agreements that allow people who were enrolled in another state's high-risk pool, met the preexisting condition period, and have not used up the lifetime benefit, to be automatically enrolled in the pools of these five states after residency is established (CFA 2000). Since HIPAA deems coverage under a high-risk pool creditable coverage, the preexisting condition exclusion period is generally waived for these enrollees.

HIPAA

HIPAA allows states to use high-risk pools to ensure that people who lose group coverage after leaving employment have access to individual coverage. Twenty-three of the 29 state high-risk pools cover those eligible under HIPAA; Alabama's high-risk pool covers only those eligible under HIPAA (CFA 2000). Federal regulations require all states to waive preexisting condition exclusion periods for this class of enrollees. This group's use of high-risk pools varies greatly among the states—its members account for less than 1 percent of enrollment in Minnesota's high-risk pool but more than half of enrollment in Montana's (Table 3). The average across 27 states is 22 percent.

Medicare Beneficiaries

Eleven states enroll Medicare beneficiaries who are unable to find supplemental coverage because of medical reasons.[6] Two of these states (Illinois and Wyoming) allow only disabled (not elderly) Medicare beneficiaries to enroll. Mississippi offers supplemental coverage to Medicare beneficiaries only if they were enrolled in the high-risk pool when they became eligible for Medicare. Washington (43%), Wyoming (38%) and North Dakota (37%) have the highest proportions of Medicare beneficiaries in their high-risk pools; Illinois (8%) has the lowest population among states that allow Medicare beneficiaries to enroll (Table 3).

II. ENROLLMENT

Excluding enrollment in Tennessee's high-risk pool (which in 1994 was integrated into the TennCare program), nearly half (47 percent) of the 105,000 people enrolled in high-risk pools nationwide in 1999 were in either California's or Minnesota's high-risk pool. Recent growth in high-risk pool enrollment has been significant (nationwide, more than 13 percent between 1998 and 1999), largely due to the enrollment of HIPAA eligibles in states that had low baseline enrollment.[7]

Potentially due both to widespread public awareness of the TennCare program and to consolidation of the eligibility determination process in Tennessee, estimated enrollment in the high-risk pool segment of TennCare is nearly as great as enrollment in all other state high-risk pools combined. Currently (in fiscal 2001), an estimated monthly average

[6] That is, the high-risk pool acts as the payer of last resort, only reimbursing a portion of those expenses Medicare does not cover.

[7] In some states with very low baseline enrollment in the high-risk pool, the recent rate of enrollment growth has been high (CFA 2000). Alabama, Alaska, Arkansas, Montana, Oklahoma, Oregon, and Texas all reported increases in enrollment between 1998 and 1999 that ranged from 40 percent (in Oregon) to more than 360 percent (in Texas).

of 94,164 enrollees in TennCare—about 7 percent of all TennCare enrollees—are eligible for TennCare only because they are uninsurable (PricewaterhouseCoopers 2000).[8]

Nationally, about 7 percent of the population younger than age 65 obtains health insurance in the individual market (Fronstin 2000). Because the health insurance market for individuals is itself relatively small, it is not surprising that only a small number of people are enrolled in every state that has a high-risk pool. However, high-risk pools also are small relative to the individually insured population these programs serve (Table 3). About 1.2 percent of each state's individually insured population is enrolled in the high-risk pool on average—and less than 2 percent in all but three states (Minnesota, Nebraska and Oregon). Relative to the individually insured population, the largest programs are in Minnesota (6%) and Nebraska (3%).[9] In absolute numbers, enrollment in California's high-risk pool, the Major Risk Medical Insurance Program (MRMIP), is large—it covered almost 21,000 in 2000—but it constitutes only about 1 percent of the state's individually insured population. Minnesota has the largest number of enrollees with almost 26,000 in 1999.

High-risk pools in California, Florida, and Illinois are closed to new enrollment.[10] California's pool has had a waiting list for most of its history because of funding constraints. As of December 1, 2000, 5,546 Californians (28.6% of current enrollment) were on the list.[11] Further lowering of enrollment caps is likely (California MRMIP 1999, California MRMIP 2000). Florida closed its pool to new enrollment in 1990, when enrollment and losses began to rise. Anticipating a deficit, Illinois capped enrollment in its high-risk program, the Comprehensive Health Insurance Plan, or CHIP, in September 2000 (CHIP 2000). While Illinois is not accepting new applications under the category of medically uninsurable, it still accepts those eligible under HIPAA.

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[8] A recent federal ruling has put the eligibility requirements for TennCare's uninsurables in question. The judge ruled that private insurance companies are not the appropriate arbiter of uninsurability and the state will have to come up with criteria other than denial letters to determine whether people qualify for TennCare because of preexisting medical conditions. The decision came in response to reports that private insurance companies were dumping chronically ill people into the public program, with some companies even charging applicants a fee for the denial letter (Snyder 2001). Independent of this ruling, under a reorganization to become effective in fiscal 2002, TennCare will retain the state high-risk pool, but financial management of the uninsurable enrollees will be separate.

[9] State individually insured population numbers are from EBRI calculations based on the 1999 March Current Population Survey.

[10] Oklahoma's authorizing statute also allows the Health Insurance High-Risk Pool board to cap enrollment if it is necessary to limit costs (CFA 2000).

[11] Blue Cross of California offers an unsubsidized look-alike plan for people on the high-risk pool waiting list, but it is unsubsidized and charges premiums higher than those available to MRMIP enrollees. On December 1, 2000, 1,834 people were enrolled in this plan (California MRMIP 2000).

The situation in these states illustrates the dilemma of high-risk pools. As enrollment increases, total pool losses typically rise, even though average losses per person may be stable. Therefore, most states do little marketing or outreach so as to keep enrollment fairly low.

III. PREMIUMS

To make high-risk pools more affordable, all states cap premiums relative to average standard rates in the market for individuals, although premiums for pool enrollees do vary by age or other factors allowed in the private market. Typical caps range from 125 to 200 percent of the average standard rates for comparable individually purchased insurance. Despite these caps, high-risk pool premiums are high, averaging $3,083 (Table 4). In 1999, the Missouri pool's average yearly premium for individual coverage was $4,920 (the highest of all pool states), which is about 12.2 percent of the state's median household income. While enrollment does not appear to be related directly to the relative level of high-risk pool premiums, the three states with the highest enrollment as a percentage of the individually insured population (Minnesota, Nebraska, and Oregon) have average premiums lower than the average for all states. Other factors that may drive the large disparity in premiums are benefit design, underlying differences in the average cost of individual insurance, and the average age and health status of pool enrollees.

In addition to a disparity in average premiums across states, there is also a wide difference in premiums for individuals enrolled within the same high-risk pool. Beneficiaries can be charged higher premiums because of all of the same risk factors allowed in the private market, e.g., age, gender, and geographic locality, with the exception of health status. Table 4 gives the span of premiums for nonelderly adults in state high-risk pools, excluding those plans designed specifically for Medicare and HIPAA-eligibles.

IV. BENEFIT DESIGN

Plan choices offered to high-risk pool enrollees vary considerably among the states. Table 5 shows plan choices by state, excluding plans that enroll only Medicare beneficiaries or those eligible under HIPAA.

Plans

Traditional fee-for-service indemnity plans are the most common plan type among high-risk pools (20 states offer at least one indemnity option). The use of indemnity plans frees the state from concerns about statewide access to a provider network and also allows enrollees to use their own providers, a feature that may be very important to those with a

history of medical problems. Third-party administrators process both enrollment and claims in all states.

Fourteen states use preferred provider organizations (PPOs), encouraging the use of network providers to constrain plan costs. When contracting with a PPO, the PPO's established network of providers is *de facto* the high-risk pool's network. If the PPO's network is statewide, the pool may contract with only one PPO to cover all of the state's service areas. Some states contract with multiple PPOs. California currently contracts with two PPOs and five HMOs, although just one of the plans accounts for more than 70 percent of total enrollment (California MRMIP 1999).

Other states that offer an HMO option are Alabama, Colorado,[12] Connecticut, Oregon, and Tennessee (through TennCare). HMOs give enrollees the benefit of lower deductibles and coinsurance in exchange for more restrictive networks.

Cost-Sharing

In every state that has a zero-deductible plan, that plan is an HMO or PPO. In states with plans that require deductibles, the amount can be as high as $10,000 in fee-for-service or PPO plans. Typically, coinsurance applies as well. This is usually set at about 20 percent of covered expenses after the deductible is met (higher for out-of-network service in a PPO plan). Several states also require copayments for physician office visits ($15 to $20) and for hospital stays ($100 to $500).

Most states cap enrollees' out-of-pocket expenses, depending on the plan chosen. These limits can be as high as $10,000 in Alaska, Oklahoma, and Texas, or even $20,000 for one of Arkansas' three options. Four states (Colorado, Florida, Kansas, and Mississippi) have at least one plan with no out-of-pocket limit.

Lifetime and Annual Limits on Benefits

All but three high-risk pools (Indiana, Kentucky, and Tennessee) limit lifetime benefits (Table 6). Indiana imposes no lifetime limit on its conventional high-risk pool. The lifetime limit of Kentucky's pool, Kentucky Access, varies with the plan chosen—some plans limit lifetime benefits to $2 million while others have no lifetime limit (Kentucky Access 2001). Tennessee has no lifetime limit on benefits because the state's medically uninsurable population is integrated into its Medicaid program (TennCare).

[12] Colorado's HMO is only available in the Denver–Boulder area.

The typical lifetime benefit limit in the other 26 pool states is $1 million, but the range is broad.[13] Minnesota's $2.8 million lifetime limit is the highest; Wyoming's low-cost option with a limit of $350,000 is the lowest. In addition to lifetime limits, benefits are capped annually in California ($75,000), Kansas ($100,000),[14] Louisiana ($100,000), and Utah ($150,000).

Preexisting Condition Exclusions

While high-risk pools are designed specifically for people with serious or chronic illnesses, every state tries to protect its pool from adverse selection by imposing preexisting condition exclusions. Enrollees who were (or reasonably might have been) diagnosed for treatment of a condition during a "look-back" period before enrolling in the pool are not covered for treatment of that condition during a specified waiting period after coverage begins. Most states set both the waiting and look-back periods at six months (Table 7). TennCare has no waiting or look-back period. Indiana has the shortest preexisting condition exclusion periods—three months for both the waiting and look-back periods. In contrast, Montana requires a waiting period of one year and looks back for three years. This is by far the longest among pool states. Preexisting condition exclusions are waived for people who can prove creditable coverage during the specified look-back period and for those eligible under HIPAA.

Condition-Related Limits

State high-risk pools typically limit coverage for specific conditions, most commonly for mental health problems and maternity. These restrictions are detailed in Table 8.

Mental Health Benefits

Nearly all pools limit mental health coverage more stringently than coverage for other medical conditions and require higher copayments for mental health treatment. Louisiana's high-risk pool excludes coverage for all mental health services.

Although mental health care limitations appear restrictive, the effect on enrollees may be modest: few enrollees actually use these services. One study of the mental health care claims data from eight state high-risk pools during 1988–91 found that few state pool enrollees use extensive mental health/substance abuse services, regardless of the generosity of the state's mental health benefits. However, those who did use mental health and

[13] In some states, individuals who reach the lifetime limit might then spend down to Medicaid eligibility, assuming that they also qualify as categorically eligible under the state's eligibility rules.

[14] Two of the five plans available in Kansas limit annual benefits; the other three plans only limit benefits on a lifetime basis.

substance abuse benefits disenrolled sooner from high-risk pools that had more restricted coverage (Stearns and Slifkin 1995).

Maternity Benefits

Ten states restrict maternity benefits. Alaska and Louisiana limit maternity coverage to major complications; Mississippi does not cover prenatal or maternity care at all. The pools in Illinois, Iowa, Nebraska, and New Mexico cover maternity expenses only as a rider that enrollees must buy separately. North Dakota and Utah require a longer waiting period for maternity coverage than for other preexisting conditions (nine months in North Dakota and 10 in Utah), which effectively precludes enrollees from using the pool solely for maternity coverage. Wyoming doubles the plan deductible for maternity coverage.

Outpatient Prescription Drugs

Every plan except Connecticut's Special Health Care Plan for eligible low-income individuals covers outpatient prescription drugs (CFA 2000). Most of the indemnity plans require beneficiaries to meet the plan deductible before they are reimbursed for prescription drugs. Alabama and Louisiana have yearly limits on prescription drug costs ($1,500 and $15,000, respectively) (CFA 2000).

V. COST

Just as enrollment levels and benefit provisions of state high-risk pools vary widely, the average cost per enrollee also differs. Table 9 shows the average cost per pool enrollee in 1999, as well as the percentage of total costs attributable to claims paid and administrative expense. That year, average costs per enrollee ranged from a low of $3,610 in Arkansas to more than $11,000 in Iowa. Medical loss ratios, defined as the ratio of claims paid to premiums earned, ranged from a low of 1.14 in Oklahoma to a high of 4.84 in Washington.[15]

Typically, the high costs of a few individuals constitute a large percentage of the claims costs. One study of claims data for eight high-risk pools from 1988–91 found that the highest-cost 5 percent of enrollees accounted for 64 to 90 percent of a pool's medical expenses (Stearns et al. 1997). More recent data from California and Illinois show a similar pattern. Approximately 20 percent of California pool enrollees made no medical claims in a year, and 85 percent had annual medical costs of less than $5,000 (California MRMIP 1999). In Illinois, 4 percent of the pool's medically uninsurable population accounted for 46 percent of the paid claims in 1999 (CHIP 2000). Minnesota's high-risk pool, the

[15] All of the high-risk pools have a medical-loss ratio greater than 1.0, indicating the premiums collected from enrollees are not enough to cover the expense of their claims.

Minnesota Comprehensive Health Association, reports a similar concentration of costs. In 1999, 235 catastrophic cases (i.e., cases with claims higher than $50,000) among the pool's 25,433 members accounted for about 26 percent of the pool's total costs (Minnesota Comprehensive Health Association 2000).

Funding

State high-risk pools draw from several funding sources to support the inevitable shortfall between premiums earned and claims paid. These are detailed in Table 10.

Assessments on Insurers

The most common source of financing is an assessment levied on health insurance carriers in the state in proportion to the insurer's share of business. Many view such assessments as an alternative to requiring insurers to guarantee issue—i.e., insurers are assessed to help cover the applicants to whom they deny coverage. Several states allow insurers to offset the assessment against their corporate income tax liability, in effect using state general revenues to finance high-risk pool operations.

Most states that use insurer assessments base the amount on the insurer's share of the total premiums earned that year by all health insurers doing business in the state. Because ERISA exempts self-insured employer plans from state taxes, an assessment on earned premiums for health insurance *de facto* exempts a large segment of health insurers from taxation, placing insured plans at a competitive disadvantage.

The funding burden for Minnesota's MCHA falls on only about half of the private insurance market because of the number of self-insured plans. In order to reduce what is perceived as an inequitable funding mechanism, MCHA has sought additional appropriations from the state since 1998. Consequently, the legislature has appropriated $15 million per year to MCHA for 1998–99 and 2001. These appropriations directly offset the assessments on contributing insurers.

Because ERISA prohibits states from taxing self-insured employer plans, both Washington and Oregon base their assessments on the number of covered lives, allowing these states to get at stop-loss insurers.[16] Kentucky and Wisconsin also have broadened the scope of their pools' revenue base by assessing the earned premiums of stop-loss insurers and reinsurers (Butler 2000). While self-insured plans have argued that a tax on stop-loss insurers represents a prohibited tax on self-insured plans, federal courts have ruled that

[16] Stop-loss insurers protect self-insured plans against high total or individual claim costs.

these assessments are legal because they affect neither the plan structure nor the administration of self-insured plans (Butler 2000).

General Revenues

Five states (Illinois, Louisiana, Tennessee, Utah, and Wisconsin) draw from general revenues to help finance their high-risk pools. To control payments to the pool, Illinois can limit enrollment in its pool. In anticipation of a $34 million deficit for the fiscal year ending June 2001 (twice the $17 million appropriation the pool received), Illinois stopped enrolling new applicants in September 2000, creating the first waiting list for the plan since 1995 (CHIP 2001). More than 740 people are currently on the waiting list. Governor George H. Ryan has recommended that the state allocate $42 million to CHIP in 2002 to make up for the shortfall and to reduce, if not eliminate, the waiting list (Holt 2001). Since enrollment for people eligible under HIPAA is funded separately, it is not capped.

There is no specific funding for high-risk enrollees within Tennessee's TennCare. Tennessee pools federal, state, and local money for indigent health care to finance its Medicaid program.

Designated Funds

Three states (California, Colorado, and Kentucky) use other earmarked funds to finance their high-risk pools. California subsidizes its pool with $40 million per year from its State Cigarette and Tobacco Products Surtax Fund (California MRMIP 1999). Because it caps enrollment to contain shortfalls to this $40 million limit, the pool has had a waiting list for most of its history. Colorado uses the state's unclaimed property and unclaimed insurance funds to help finance its high-risk pool.[17] Kentucky's new pool is the first to use money from the tobacco settlement.

Two states (Minnesota and Louisiana) have used revenues from a surcharge on hospital admissions and outpatient procedures. Like assessments on insurers' earned premiums, this revenue base is attractive because it expands at approximately the same rate as per capita medical costs. Minnesota used a portion of the state's Health Care Access Fund, which collects money from the state's 1.5 percent tax on hospital and provider charges, as an emergency appropriation in 1998 and 1999 to help fund its high-risk

[17] The unclaimed property fund consists of unclaimed wages, utility deposits, and gift certificates. The unclaimed insurance fund consists of proceeds from insurance policies for which no beneficiary can be found (CFA 2000).

pool.[18,19] Louisiana collects a service charge of $2 per day on inpatient admissions and $1 on outpatient procedures to help finance its high-risk pool. The state directly assesses all patients whose insurer does not cover the service charge (CFA 2000).

Subsidies for Low-Income Eligibles

Because high-risk pool premiums are generally high and unaffordable for many, six states (Colorado, Connecticut, New Mexico, Oregon, Tennessee, and Wisconsin) operate special programs for low-income people eligible for the high-risk pool. The programs help reduce premiums and/or cost-sharing requirements.

Wisconsin has the oldest low-income subsidy program, the Wisconsin Health Insurance Risk Sharing Plan's (HIRSP) Premium and Deductible Reduction Plan, established in 1985. The program offers an income-related premium and deductible to enrollees with annual household incomes of less than $25,000 (Wisconsin HIRSP 2001). Those eligible qualify for a 20 percent to 35 percent premium reduction, and deductibles may also be set lower—from $500 to $800 instead of the usual $1,000 (CFA 2000). In 1999, about 35 percent of the pool's enrollees participated in the low-income program (CFA 2000). The subsidy program is financed with a state appropriation, periodic assessments of health insurers, and adjustments to provider payments. The Wisconsin legislature appropriated $1.56 million for its HIRSP Premium and Deductible Reduction Plan for the 1999–2001 biennium (CFA 2000).

Five other states have special programs for low-income, high-risk pool enrollees:

- Connecticut operates a Special Health Care Plan that reduces the usual annual deductible of $500 to $200 for eligible people with annual incomes of less than 200 percent of the federal poverty level. After the enrollee reaches the deductible, the plan pays providers 75 percent of the Medicare reimbursement level. Health care providers must accept this as full payment (CFA 2000).
- Colorado's high-risk pool offers a 20 percent premium discount to eligible people who live outside the Denver–Boulder area and have annual household incomes of less than $30,000 (Colorado Uninsurable Health Insurance Plan 2000). Even with the 20 percent discount, health insurance premiums constitute almost 9 percent of

[18] Most of the Health Care Access Fund's resources go toward the operation of MinnesotaCare, a low-income health care subsidy program.

[19] Because providers pass on this tax directly to health care buyers, self-insured purchasers challenged this tax under ERISA. The tax was upheld in court (Butler 2000).

annual household income for a high-risk pool enrollee with an income of $30,000.[20]

- New Mexico residents with incomes less than 200 percent of the federal poverty level qualify for a premium subsidy of as much as 25 percent. Even with the full 25 percent subsidy, a family of four with an income of 120 percent of the federal poverty level ($20,958) would still spend almost 10 percent of annual household income to enroll one person in the pool.[21] Approximately 17 percent of New Mexico's enrollees receive some subsidy (CFA 2000).
- Uninsurable enrollees in TennCare pay premiums on the same sliding income scale as other TennCare enrollees. These begin at $0 for people at or below the federal poverty level and are scaled up according to income. Those in the highest income category (income more than 750 percent of the federal poverty level) pay the full cost of coverage without a state subsidy (CFA 2000).
- In Oregon, a separate state program, the Family Health Insurance Assistance Program (FHIAP), provides a subsidy to people with incomes of up to 170 percent of the poverty level. The subsidy pays 70 to 90 percent of premiums for individuals who have been uninsured for six months or who are leaving Medicaid, and it may be used to buy into the high-risk pool. As of June 1999, FHIAP subsidized one-quarter of the high-risk pool's 5,696 members (Oregon Medical Insurance Pool 1999).
- As of 2001, Washington has added special discounts to its high-risk pool program. Enrollees ages 50–64 with incomes of less than 300 percent of poverty and those enrolled in the Washington State Health Insurance Program for more than three years are eligible for the discounts (Washington State Insurance Commissioner 2001).

VI. ALTERNATIVES OR COMPLEMENTS TO STATE HIGH-RISK POOLS

Some states have legislated reforms of the private insurance market to improve access and affordability in the individual market. Thirteen states require insurers to guarantee issue or hold open-enrollment periods—therefore they have not needed to organize a high-risk pool.[22] Sixteen states limit the extent to which insurers may vary premiums to reflect health status and/or the extent to which insurers may vary rates overall. Eight states

[20] Calculation uses average annual premium (Table 4) and median household income information from the U.S. Department of the Census.

[21] Federal poverty level information for 1999 is from the U.S. Department of the Census. Calculations use average annual premiums (Table 4).

[22] Another three states have guaranteed-issue requirements in addition to high-risk pools.

prohibit insurers from considering health status in setting rates. Details of these regulations in each state are presented in Table 11.

Rate Restrictions

Some states impose rate bands that limit premium variations based on health status. Composite rate bands limit total rate variation. Because rate bands improve affordability but not access, nearly all states with rate bands also have enacted some other reform in the market for individuals—e.g., guaranteed issue of some or all products for individuals, a high-risk pool, or an open-enrollment period. Health status rate bands range from community rating (in eight states) to over a 2:1 ratio in Kentucky.

Composite rate bands restrict the extent to which insurers can rate up for all allowable risk factors (e.g., health status, age, and gender). New Jersey and New York require full community rating (no variation in rates except by geographic area and family size). In contrast, Kentucky and North Dakota both allow up to a fivefold difference between high and low rates, and 39 states and Washington, D.C., have no restriction on composite rates.

Guaranteed Issue—All Products

Eleven states require guaranteed issue of all individual insurance policies. Six of these (Hawaii, Maine, New Hampshire,[23] New Jersey, New York, and Vermont) have continuous guaranteed issue. Insurers writing individual coverage may not deny coverage due to health status at any time during the year. Each of these states requires community rating on health status.

Massachusetts and Ohio have periodic guaranteed-issue requirements. Insurers must have periodic open-enrollment periods during which all applicants can obtain coverage regardless of health status. While Massachusetts prohibits insurers from varying rates by health status, Ohio allows insurers to rate on health status and other factors.

Rhode Island has adopted guaranteed issue for individuals with 12 months of continuous previous coverage. Like Ohio, Rhode Island allows insurers to rate on health status and other factors.

[23] As part of a package of reforms to New Hampshire's individual insurance market passed in 2001, insurers will be allowed to vary individual premiums according to age and health status beginning July 2002. New Hampshire will also begin operating a high-risk pool.

Utah and Washington both have limited guaranteed-issue requirements in their individual health insurance markets, and (unlike other states with access regulation in the individual market) they also operate high-risk pools. Both states require insurers to use standardized underwriting guidelines that define "high-risk" conditions.[24] High-risk applicants who are denied private coverage become eligible for the state high-risk pool. However, if the pool determines that the applicant does not meet the state's guidelines, the insurer must issue coverage.[25]

Guaranteed Issue—Some Products

Another five states (Idaho, Iowa, Maryland, South Dakota, and West Virginia) require some or all insurers in the individual market to guarantee issue of at least one basic product, but not of all of the products they offer.[26] Only Iowa also has a high-risk pool. None of these states requires community rating, and some do not restrict insurers from rating up for past or continuing health problems.

Idaho requires insurers to make four standard health plans continuously available to high-risk applicants. The four plans for high-risk individuals are then integrated into a state reinsurance pool (CFA 2000).

Iowa and South Dakota require insurers to offer two plans to individuals who have 12 months of prior continuous coverage and limit the amount that insurers may rate up premiums for health status. Iowa's high-risk individuals who do not qualify with previous coverage may enroll in the state high-risk pool (the Iowa Comprehensive Health Association, or ICHA). After remaining in ICHA for 12 months, they must return to the private insurance market where they are guaranteed issue (Institute for Health Care Research and Policy 2000).

Insurer of Last Resort

Washington, D.C., Michigan, Pennsylvania, and Virginia do not require all insurers to accept high-risk individuals; instead they have identified an insurer of last resort. While all other insurers may deny applicants because of their health status, these people are guaranteed coverage from the designated insurer, usually a Blue Cross or a Blue

[24] Washington's guidelines are intended to identify the sickest 8 percent of the population as high-risk and eligible for the Washington State Health Insurance Pool.

[25] High-risk pool enrollees in Utah who turn out not to be high cost are returned to the private market and insurers must issue a policy to that individual.

[26] Maryland and West Virginia require only HMOs that write individual policies to offer open-enrollment periods during the year. The insurer may not deny coverage due to health status during these periods. Currently only one HMO in West Virginia participates in the individual market and it covers only some of the state's counties.

Shield organization.[27] Typically, these states also limit the extent to which this insurer can rate up for health status. For example, Michigan requires Blue Cross/Blue Shield to community rate.

States Without Regulation

Four states (Arizona, Delaware, Georgia, and North Carolina) have no specific regulation of the individual insurance market designed to improve either access to or affordability of coverage for people with significant health problems. People who are denied health insurance in these states have no apparent options for coverage.

VII. SUMMARY AND CONCLUSION

In 2001, 29 states operated high-risk insurance pools. Most (23) of these states also use their high-risk pools to guarantee coverage to eligible people entering the individual market from group coverage as required by HIPAA. Only Alabama operates its high-risk pool exclusively for those eligible under HIPAA. Enrollment in the high-risk pool in nearly all states is small relative to the individual insurance market that these pools are intended to support. Only in Minnesota, Nebraska, Oregon, and Wisconsin did 1999 enrollment reach 2 percent of the individually insured population. The small size of pool enrollment is attributed to their high premiums and, in many states, to the very limited benefits they offer. Moreover, because all states must find ways to cover shortfalls between premiums earned and costs incurred, some have capped enrollment; most do not conduct extensive advertising or outreach to attract enrollment.

Most states assess health insurers to support their high-risk pools. Some states fund all or part of the pool directly from general revenues; those that allow insurers to offset the assessment against their corporate income tax liability in effect also fund the high-risk pool from general revenues. A few states use other earmarked funds to finance their high-risk pools exclusively or in addition to general revenues. A heavy reliance on these alternative sources of funding can cause a recurring crisis for the high-risk pool if the revenue base does not expand with growth in health care costs.

Affordability and sustainability are paramount among the difficult issues high-risk pools raise for consumers and states. Several states subsidize the participation of those with low incomes in the high-risk pool, but the subsidized premiums remain high relative to income even in these states. While all states need broad funding for the high-risk pool, those without an earmarked (and therefore, relatively narrow) revenue base may find it

[27] Blue Cross/Blue Shield in Washington, D.C. is required to have a six-month open-enrollment period.

difficult to maintain support for the pool when budgets become tight. Efforts to control plan costs by severely limiting coverage obviously defeat the purpose and usefulness of a high-risk pool, but also illustrate the dilemma many states face in maintaining adequate funding.

Some states have adopted innovative strategies to maintain adequate benefits and better affordability in their high-risk pools. Specifically, some have broadened these pools' conventional funding base by assessing covered lives rather than insurer premiums or by including stop-loss premiums with the traditionally assessed premiums.

It is possible to imagine the development of a combination that would achieve both a broad revenue base and some growth with the general growth of health care costs. This might be achieved if Congress were to offer states relief from ERISA's provisions that preempt state taxation of self-insured employer plans for the purpose of high-risk pool financing. Some states have tried to approach this result by augmenting their assessment on insurers with an earmarked surcharge on provider revenues, despite obvious opposition from providers.

In addition, some states have enacted regulation to improve access and affordability in the health insurance market for individuals, either instead of organizing a high-risk pool or in addition to a high-risk pool. Consumers with health problems in these states may have the broadest options for finding health insurance.

Two states, Utah and Washington, maintain high-risk pools and have reformed the health insurance market for individuals as well. These states have attempted to limit the continuing problem of financing high-risk pool losses without severely restricting the adequacy of benefits. Both require private insurers to accept more risk, but also allow them to deny designated risk. These mixed systems offer a promising model—balancing the interests of consumers, insurers and taxpayers day-to-day—for states in which individuals denied private insurance have no alternative source of coverage, and also for states with recurring crises of funding for their high-risk pools.

TABLES

Table 1
Populations Eligible for High-Risk Pool Enrollment by State, 2001

	Medically Uninsurable	HIPAA Eligibles	Medicare Beneficiaries	Other
Alabama		X		
Alaska	X	X	X	
Arkansas	X	X		
California	X			Waiting list
Colorado	X			
Connecticut	X	X		Anyone ages 19–64 with no insurance
Florida	X		X	Not open to new enrollment
Illinois	X	X	X (disabled only)	Waiting list for medically uninsurable
Indiana	X	X		
Iowa	X	X	X	
Kansas	X	X		
Kentucky	X	X		
Louisiana	X	X		
Minnesota	X	X	X	Those older than 65 and ineligible for Medicare
Mississippi	X	X	May keep as carve-out	
Missouri	X			
Montana	X	X	Medicare carve-out	
Nebraska	X	X		
New Mexico	X	X		
North Dakota	X	X	X	
Oklahoma	X	X		
Oregon	X	X		
South Carolina	X	X		
Tennessee	X			
Texas	X	X		
Utah	X	X		
Washington	X		X	
Wisconsin	X	X	X	
Wyoming	X	X	X (disabled only)	

Source: Communicating for Agriculture 2000.

Table 2
State Requirements to Prove Uninsurability, 2001

	Denied Insurance	Quoted Rate Relative to Pool Rate	Coverage Terminated	Reciprocity Agreement	Restrictive Rider	Qualifying Condition	Agent Statement	Notes
Alabama								Enrolls only HIPAA-eligibles
Alaska	X				X	X		
Arkansas	X	>100%						
California	X	>100%	X	X				
Colorado	X	>100%			X	X		
Connecticut								Do not need to prove uninsurability
Florida	X(2)	>100%			X			
Illinois	X	>100%				X		
Indiana	X	>100%				X		
Iowa	X	>100%			X	X		
Kansas	X(2)	>100%	X		X			
Kentucky	X(2)	>100%				X		
Louisiana	X(2)	>200%		X				
Minnesota	X		X		X	X		
Mississippi	X	>100%	X	X		X		
Missouri	X	>300%	X		X			
Montana	X(2)				X	X		
Nebraska	X	>100%			X	X		
New Mexico	X	>100%		X	X			
North Dakota	X				X			
Oklahoma	X(2)							
Oregon	X		X				X	
South Carolina	X	>150%			X			
Tennessee	X							
Texas	X	>100%			X	X	X	
Utah	X			X				Must meet pool's underwriting criteria
Washington	X	>100%			X			Must be screened as part of sickest 8% of individual market
Wisconsin	X				X	HIV+		Quoted rate increase 50% or more
Wyoming	X	>100%			X			

Notes: (2) indicates applicant must show proof of rejection from two insurers. States with reciprocity agreements allow individuals who move from another state with a high-risk pool to enroll in this state's pool without proof of denial.

Source: Communicating for Agriculture 2000.

Table 3
High-Risk Pool Enrollment by State
(Enrollment as of December 31, 1999, unless otherwise noted)

States (ranked by total enrollment)	Total Enrollment	Enrollment			Percent of Enrollment			Ratio of Pool Enrollment to Individually Insured Population*
		Medically Uninsurable	HIPAA-Eligible	Medicare-Eligible	Medically Uninsurable	HIPAA-Eligible	Medicare-Eligible	
27 STATES	112,708	na	na	na	71.5%[5]	21.8%[5]	7.9%[5]	1.2%[5]
Minnesota[1]	25,892	21,435 (est)	33	4,424 (est)	82.8%	0.1%	17.1%	6.0%
California	20,834	20,834	na	na	100.0%	0.0%	0.0%	1.0%
Illinois[1]	9,099	4,778	3,633	688	52.5%	39.9%	7.6%	1.7%
Texas[1]	8,600	5,815	2,785	na	67.6%	32.4%	0.0%	0.8%
Wisconsin	7,904	5,760	852	1,292	72.9%	10.8%	16.3%	1.5%
Oregon[2]	5,833	5,237	596	na	89.8%	10.2%	0.0%	2.5%
Indiana[1]	5,333	4,880	453	na	91.5%	8.5%	0.0%	1.4%
Nebraska[1]	5,023	—	—	na	—	—	0.0%	2.7%
Alabama[1]	2,431	na	2,431	na	0.0%	100.0%	0.0%	0.9%
Mississippi	2,017	1,634	383	na	81.0%	19.0%	0.0%	1.3%
Washington[1]	1,897	1,087	na	810	57.3%	0.0%	42.7%	0.3%
Connecticut	1,726	1,104 (est)	622	na	64.0%	36.0%	0.0%	1.1%
Montana	1,687	802	885	na	47.5%	52.5%	0.0%	1.9%
Arkansas	1,675	1,089	586	na	65.0%	35.0%	0.0%	0.9%
Oklahoma[1]	1,632	1,189	443	na	72.9%	27.1%	0.0%	0.8%
Colorado[3]	1,536	1,536	na	na	100.0%	0.0%	0.0%	0.7%
North Dakota	1,302	—	—	483	—	—	37.1%	1.3%
South Carolina	1,210	678	532	na	56.0%	44.0%	0.0%	0.6%
Kansas	1,202	760	442	na	63.2%	36.8%	0.0%	0.6%
Utah[4]	1,106	692	414	na	62.6%	37.4%	0.0%	0.9%
New Mexico[1]	1,030	989	41	na	96.0%	4.0%	0.0%	1.2%
Louisiana	1,026	763	263	na	74.4%	25.6%	0.0%	0.5%
Florida	811	565	na	246	69.7%	0.0%	30.3%	0.1%
Missouri	761	761	na	na	100.0%	0.0%	0.0%	0.2%
Wyoming	570	349	6	215	61.2%	1.1%	37.7%	1.2%
Iowa[1]	303	—	—	43	—	—	14.2%	0.1%
Alaska	268	234	9	25	87.3%	3.4%	9.3%	0.7%

Notes: Enrollment from December 1999. Tennessee has no information about the proportion of its TennCare population that is eligible as medically uninsurable.
* Author's calculation. Percent equals the number of enrolled individuals not eligible for Medicare divided by the state's nonelderly individually insured population.
[1] Enrollment as of June 30, 2000. [2] Enrollment as of May 31, 2000. [3] Enrollment as of August 1, 2000. [4] Enrollment as of July 20, 2000. [5] Average for 27 states.
na = not applicable; (est) = estimated from available information; — = population is eligible but enrollment information is not available.

Sources: Communicating for Agriculture 2000. Estimates for individually insured population are based on EBRI estimates derived from the March 1999 Current Population Survey.

Table 4
Annual Premiums by State

States (ranked by average yearly premium)	1999 Average Yearly Premium*	2001 Premium Range	Average Premium/1999 Median Household Income*	Premium Cap as a Percentage of Average Comparable Plan
AVERAGE—29 STATES	$3,083	na	8.1%	168%
Washington	$1,832	$1,370–$8,734	3.9%	125%–150%
Minnesota	$2,042	$1,040–$3,953	4.4%	125%
Oregon	$2,202	$1,620–$6,120	5.5%	125% uninsurable, 100% HIPAA
California	$2,435	$1,300–$10,284	5.8%	125%–137.5%
Arkansas	$2,486	—	8.8%	150%
North Dakota	$2,550	$1,636–$5,504	7.9%	135%
Texas	$2,593	$876–$11,628	6.9%	125%–200%
New Mexico	$2,595	$1,068–$7,068	8.1%	150%
Wisconsin	$2,611	$888–$7,200	6.1%	200%
Montana	$2,645	$2,127–$5,762	8.5%	200% uninsurable, 150% HIPAA
Alabama	$2,685	$1,476–$6,072	7.6%	200%
Wyoming	$2,738	$1,860–$6,864	7.6%	125%–150%
Nebraska	$2,926	—	7.8%	135%
Colorado	$2,989	$600–$8,810	6.4%	150%
Mississippi	$3,041	$1,572–$6,168	9.9%	150%–175%
Louisiana	$3,047	$614–$7,749	9.2%	125%–200%
Alaska	$3,224	$1,394–$12,188	6.3%	200%
Kansas	$3,297	$1,608–$6,710	8.8%	Reasonable
Illinois	$3,544	$1,164–$11,760	8.0%	125%–150%
Indiana	$3,545	$786–$7885	8.7%	150%
Oklahoma	$3,631	$714–$7,727	10.9%	150%
Florida	$3,665	—	10.4%	200%–250%
Utah	$3,668	$2,149–$5,136	8.1%	Reasonable
Iowa	$3,896	$2,710–$11,624	10.2%	150%
Connecticut	$3,985	—	8.3%	125%–150%
South Carolina	$4,434	$1,874–$8,998	12.5%	200%
Missouri	$4,920	—	12.2%	150%–200%
Tennessee	na	$0–$2,945	na	Part of TennCare's sliding scale
Kentucky	na	$1,798–$11,056	na	150%–175%

Notes: Average Yearly Premium = Total Premiums Collected/Total Enrollment. Premium Range is lowest available adult premium to highest premium for adults under 65.
* Author's calculations.
na = not applicable.
— = not available.

Sources: Communicating for Agriculture 2000. Median Household Income from U.S. Census Bureau, Current Population Survey, March 2000.

Table 5
Cost-Sharing in High-Risk Pools by State, 2001

State	Plan Type	Deductible	Coinsurance/Copayments	Out-of-Pocket Maximum
Alabama	Indemnity	$250/500/1,000	20% outpatient, 0% inpatient	$1,250/1,500/2,000
	HMO	None	$20 outpatient, $500 inpatient	na
Alaska	Indemnity	$500/1,000/1,500	20%	$2,000
	Indemnity	$2,500	20%	$3,500
	Indemnity	$5,000	20%	$7,500
	Indemnity	$10,000	20%	$10,000
Arkansas	PPO	$1,000	20% in-network, 40% out-of-network	$2,000 (in-network only)
	PPO	$5,000	20% in-network, 40% out-of-network	$10,000 (in-network only)
	PPO	$10,000	20% in-network, 40% out-of-network	$20,000 (in-network only)
California	PPO	None	25% in-network, 30% out-of-network	$2,500
	HMO	None	Depends on plan chosen	$2,500
Colorado	PPO	$300/500	20% in-network, 40% out-of-network	none
	PPO	$750/2,000/5,000	25% in-network, 50% out-of-network	none
	HMO	None	$15 office visit, $100 inpatient	$2,000
Connecticut	HMO	None	$10 office visit, $500 inpatient	$2,500
	PPO	$500	20% in-network, 40% out-of-network	$2,500 in-network, $5,000 out-of-network
	Low-Income Indemnity	$200	25%	$200
	Indemnity	$500	25%	$2,500
Florida	Indemnity	$1,000/1,500/2,000/5,000/10,000	10% for those under case management 20% for those using provider network 40% for others coinsurance reduced after $10,000 in costs	none
Illinois	Indemnity	$500/1,000/1,500/2,500	20%	$2,000/2,500/3,000/4,000
	PPO	$500/1,000/1,500/2,500	20% in-network hospital, 40% out-of-network	$2,000/2,500/3,000/4,000
Indiana	PPO	500/1,000/1,500	20% in-network, 40% out-of-network	$1,500/3,000/4,000
Iowa	Indemnity	$500/1,000/1,500/2,000	20%	$1,500/2,000/2,500/3,000
Kansas	PPO	$500/1,500	30%**	$2,000/3,000
	PPO	$1,000/5,000	30% of first $5,000, 10% thereafter	none
	MSA	$2,250	30% of first $2,500, none thereafter	$3,000
Kentucky	Indemnity	$400	20% outpatient, 15% inpatient**	$1,500
	PPO	$400/1,000/1,500 in-network and $700/1,500/2,250 out-of-network	15% inpatient, 20% outpatient in-network 35% inpatient, 40% outpatient out-of-network	$1,500/2,500/4,000 in-network $2,500/4,000/5,000 out-of-network
	PPO	$750/1,500	20% in-network, 40% out-of-network	$3,000/5,000
Louisiana	Indemnity	$1,000	25%	$4,500
	Indemnity	$2,000/3,500/5,000	25%	$6,500

State	Plan Type	Deductible	Coinsurance/Copayments	Out-of-Pocket Maximum
Minnesota	Indemnity	$500/1,000	20%	$3,000
Mississippi	Indemnity	$500/1,500	20%	None
Missouri	PPO	$500/1,000	20% in-network, 50% out-of-network	$2,500/5,000, none out-of-network
Montana	Indemnity	$1,000	20%	$5,000
Nebraska	Indemnity	$250/500/1,000/2,000	20%	$1,500
	PPO	$250/500/1,000/2,000 in-network and $500/1,000/2,000/4,000 out-of-network	20% in-network, 30% out-of-network	$2,000 in-network, $3,000 out-of-network
New Mexico	Indemnity	$500/1,000/2,000	20%	$2,000/3,000/5,000
	Indemnity	$5,000	$0 after deductible is met	$5,000
North Dakota	Indemnity	$500/1,000	20%	$3,000
Oklahoma	PPO	$500/1,000/1,500/2,000/5,000/7,500	20% in-network, 40% out-of-network	$10,000
Oregon	Indemnity	$300	20%	$1,300
	PPO	$300	20% in-network, 40% out-of-network	$1,300
	HMO	$300 prescription deductible only	$15 office visit, $200 + 20% inpatient	$1,000 Medical, $1,000 Prescription
	Low-Cost/ Limited Benefit Indemnity	$1,000 medical/$1,000 prescription	30%	$4,000
South Carolina	Indemnity	$500	—	$1,500
	PPO	$500	—	$2,000 in-network, $7,000 out-of-network
Tennessee*	HMO	$250	10%	—
Texas	PPO	$500	20% in-network, 40% out-of-network	$2,500 in-network, $4,500 out-of-network
	PPO	$1,000	20% in-network, 40% out-of-network	$4,000 in-network, $7,000 out-of-network
	PPO	$2,500	20% in-network, 40% out-of-network	$10,000 in-network, $17,500 out-of-network
Utah	Indemnity	$500/1,000	20%	$1,500/2,000
Washington	Indemnity	$500/1,000/1,500	20%	$1,500/2,500/3,500
Wisconsin	Indemnity	$1,000/2,500	20%	$2,000/3,500
Wyoming	Indemnity	$500 inpatient, $2,000 all other	20%–30%	$4,000
	Indemnity	$250 inpatient, $1,000 all other	20%–30%	$2,000

Notes: Colorado HMO plan only offered in the Denver–Boulder area.
* The TennCare program operates on a sliding-scale basis for deductibles and copayments.
** Out-of-network coinsurance rates unknown.
— = not available.
na = not applicable.

Sources: Communicating for Agriculture 2000. State High-Risk Pool Websites for Alaska, California, Colorado, Illinois, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oregon, Tennessee, Texas, Washington, and Wisconsin.

Table 6
Lifetime and Annual Benefit Limits, 2001

States (ranked by lifetime limit)	Lifetime Limit	Annual Limit
Indiana	none	
Tennessee	none	
Kentucky	None for standard plan, $2,000,000 for others	
Minnesota	$2,800,000	
New Mexico	$1,500,000	
Alabama	$1,000,000	
Alaska	$1,000,000	
Arkansas	$1,000,000	
Connecticut	$1,000,000	
Illinois	$1,000,000	
Iowa	$1,000,000	
Kansas	$1,000,000	$100,000 for 2 of 5 plans
Missouri	$1,000,000	
Montana	$1,000,000	
Nebraska	$1,000,000	
North Dakota	$1,000,000	
Oregon	$1,000,000	
South Carolina	$1,000,000	
Texas	$1,000,000	
Utah	$1,000,000	$200,000
Wisconsin	$1,000,000	
California	$750,000	$75,000
Colorado	$500,000	
Florida	$500,000	
Louisiana	$500,000	$100,000
Mississippi	$500,000	
Oklahoma	$500,000	
Washington	$500,000	
Wyoming	$350,000/$600,000	

Notes: Lifetime limits in Kentucky and Wyoming depend on the plan chosen.
Source: Communicating for Agriculture 2000.

Table 7
High-Risk Pool Waiting and Look-Back Periods for Preexisting Conditions

States (ranked by length of waiting period)	Waiting Period	Look-Back Period
Connecticut	12 months	6 months
Florida	12 months	6 months
Kentucky	12 months	6 months
Missouri	12 months	6 months
Montana	12 months	3 years
Oklahoma	12 months	6 months
Texas	12 months	6 months
Wyoming	12 months	6 months
Alaska	6 months	3 months
Arkansas	6 months	6 months
Colorado	6 months	6 months
Illinois	6 months	6 months
Iowa	6 months	6 months
Louisiana	6 months	6 months
Minnesota	6 months	90 days
Mississippi	6 months	6 months
Nebraska	6 months	6 months
New Mexico	6 months	6 months
Oregon	6 months	6 months
South Carolina	6 months	6 months
Utah	6 months	6 months
Washington	6 months	6 months
Wisconsin	6 months	6 months
North Dakota	180 days	90 days
Indiana	3 months	3 months
California	90 days	6 months
Kansas	90 days	6 months
Alabama	na	na

na = not applicable.

Source: Communicating for Agriculture 2000.

Table 8
State Limits on Mental Health and Maternity Benefits, 2001

State	Mental Health Limits	Maternity Limits
Alabama	30 inpatient days/year, outpatient copay 50%.	
Alaska	50% copay, $4,000/year limit on outpatient expenses.	Major complications only.
Arkansas	50% copay, $4,000/year limit.	
California	10 inpatient days/year, 20 outpatient visits/year.	
Colorado	PPO: 45 inpatient days/year, $2,500/year outpatient. HMO: 50% copay, $1,500/year outpatient.	
Connecticut	60 inpatient days/year, $2,000/year outpatient.	
Florida	30 inpatient days/year, 60 outpatient visits/year.	
Illinois	45 inpatient days/year, 50 outpatient visits/year.	Covered only as rider.
Indiana	45 inpatient days/year, 50 outpatient visits/year.	
Iowa	20 outpatient visits/year.	Covered only as rider.
Kansas	20 visits/year.	
Kentucky	21 inpatient days/year, 20 outpatient visits/year. Can purchase rider for additional coverage.	
Louisiana	Not covered.	Major complications only.
Minnesota		
Mississippi	"Substantial Limitations." Out-of-pocket costs do not apply to out-of-pocket maximum.	Not covered.
Missouri	$25,000 lifetime maximum. 30 inpatient days/year, $3,000/year outpatient.	
Montana	Not covered.	
Nebraska	$25,000 lifetime maximum. 50% copay.	Covered only as rider.
New Mexico	$30,000 lifetime maximum.	Covered only as rider.
North Dakota	Limitations vary.	9-month waiting period (instead of 6).
Oklahoma	$4,000/year. 50% copay.	
Oregon	$4,000/year on inpatient, $2,000/year outpatient. Low-cost plan does not cover.	
South Carolina	$10,000 lifetime maximum. 50% copay. 14 inpatient days/year, 20 outpatient visits/year.	
Tennessee		
Texas	Only serious mental illness. 45 inpatient days/year, 60 outpatient visits/year.	
Utah	10 inpatient days/year.	10-month waiting period (instead of 6).
Washington	30 inpatient days/year, 20 outpatient visits/year.	
Wisconsin	60 inpatient days/year, $3,000/year outpatient.	
Wyoming	Higher deductibles. $5,000/year inpatient, 30 outpatient visits/year.	Deductible is doubled.

Notes: Blanks indicate no separate limit on coverage.

Sources: Communicating for Agriculture 2000. State High-Risk Pool Websites for Alaska, California, Colorado, Illinois, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oregon, Tennessee, Texas, Washington, and Wisconsin.

Table 9
Measures of High-Risk Pool Cost by State, 1999

States (ranked by total cost per enrollee)	Total Cost/ Enrollee	Claims/ Total Cost	Administrative Cost/ Total Cost	Medical Loss Ratio
Arkansas	$3,610	91.52%	8.48%	1.33
Oregon	$3,982	93.26%	6.74%	1.69
Alabama	$4,190	98.24%	1.76%	1.53
Minnesota	$4,221	94.63%	5.37%	1.96
Mississippi	$4,280	94.85%	5.15%	1.33
North Dakota	$4,329	96.89%	3.11%	1.65
Oklahoma	$4,380	94.80%	5.20%	1.14
Wisconsin	$4,501	90.45%	9.55%	1.56
Wyoming	$4,552	98.55%	1.45%	1.77
Montana	$4,746	93.94%	6.06%	1.69
Colorado	$4,884	84.26%	15.74%	1.38
California	$5,048	95.00%	5.00%	1.97
Nebraska	$5,405	95.10%	4.90%	1.76
Utah	$5,504	90.65%	9.35%	1.36
Kansas	$5,740	94.62%	5.38%	1.53
Texas	$6,101	93.57%	6.43%	2.20
New Mexico	$6,257	93.33%	6.67%	2.25
Connecticut	$7,202	93.42%	6.58%	1.69
South Carolina	$7,368	92.78%	7.22%	1.54
Illinois	$7,569	93.71%	6.29%	2.00
Louisiana	$7,872	89.63%	10.37%	2.32
Florida	$7,967	94.05%	5.95%	2.04
Indiana	$8,963	96.04%	3.96%	2.43
Missouri	$9,404	97.25%	2.75%	1.86
Washington	$9,517	93.15%	6.85%	4.84
Alaska	$10,612	88.57%	11.43%	2.92
Iowa	$11,145	92.19%	7.81%	2.64
Tennessee	—	—	—	—
Kentucky	—	—	—	—

Notes: Total Cost is defined as Claims Paid + Administrative Expenses. Medical Loss Ratio is Claims Paid/Premiums Earned. Tennessee has no information about the proportion of TennCare's costs attributable to its uninsurable population. Kentucky's high-risk pool began operation January 1, 2001.

Source: Author's calculations based on information from Communicating for Agriculture 2000.

Table 10
Sources of Funding by State, 2001

State	State Funds	Assessments to Association Members	Other
Alabama		Yes	
Alaska		Yes	
Arkansas		Yes	
California	Cigarette and tobacco tax		
Colorado	Unclaimed property and insurance funds		
Connecticut		Yes	
Florida		Yes	
Illinois	General revenues for medically uninsurable	Yes—For HIPAA eligible	
Indiana		Yes—Can offset taxes	
Iowa		Yes—Can offset taxes	
Kansas		Yes—Can offset taxes	Premiums are to be nearly self-sustaining
Kentucky	Tobacco settlement funds	Yes	
Louisiana	General revenue		Service charge on inpatient days and outpatient procedures
Minnesota	Emergency funding from state trust funds	Yes	
Mississippi			Assesses insurers $1/covered person/month
Missouri		Yes—Can offset taxes	
Montana		Yes—Can offset taxes	
Nebraska		Yes—Can offset taxes	
New Mexico		Yes—Can offset taxes	
North Dakota		Yes—Can offset taxes	
Oklahoma		Yes—Can offset taxes	
Oregon		Yes	
South Carolina		Yes—Can offset taxes	
Tennessee			Federal, state, and local money for indigent health care
Texas		Yes	
Utah	Emergency funding from general revenue		
Washington		Yes—Can offset taxes	
Wisconsin	General revenue	Yes	Health care provider discounts on billed charges
Wyoming		Yes—Can offset taxes	

Source: Communicating for Agriculture 2000.

Table 11
Individual Insurance Market Reforms by State, 2001

State	High-Risk Pool	Guaranteed Issue—All	Guaranteed Issue—Some	Insurer of Last Resort	Rate Bands (Ratio of High to Low)		
					Health Status	Age	Composite
Alabama	X[1]						
Alaska	X						
Arizona							
Arkansas	X						
California	X						
Colorado	X						
Connecticut	X						
Delaware							
District of Columbia				X[2]			
Florida	X[3]						
Georgia							
Hawaii		C[4]			—	—	—
Idaho			C[5]		1.67		
Illinois	X						
Indiana	X						
Iowa	X		Q[6]		2		
Kansas	X						
Kentucky	X				2.07	5	5
Louisiana	X				1.5		
Maine		C			1	1.5	1.5
Maryland			P[7]				
Massachusetts		P			1	2	2
Michigan				X			
Minnesota	X				1.67	3	
Mississippi	X						
Missouri	X						
Montana	X						
Nebraska	X						
Nevada					1.75		1.5
New Hampshire		C[8]			1	3	3
New Jersey		C			1	1	1
New Mexico	X						

State	High-Risk Pool	Guaranteed Issue—All	Guaranteed Issue—Some	Insurer of Last Resort	Rate Bands (Ratio of High to Low)		
					Health Status	Age	Composite
New York		C			1	1	1
North Carolina							
North Dakota	X				1	6	5
Ohio		P[9]					
Oklahoma	X						
Oregon	X				1	3	2
Pennsylvania				X			
Rhode Island		Q					
South Carolina	X						
South Dakota			Q		1.9	5	
Tennessee	X						
Texas	X						
Utah	X	C[10]			1.86		
Vermont		C			1	1.5	1.5
Virginia				X			
Washington	X	C[11]				4	4
West Virginia			P[12]				
Wisconsin	X						
Wyoming	X						

C = Continuous; P = Periodic, open-enrollment periods; Q = Guaranteed issue applies only to qualified individuals with 12 months previous coverage.
— = not available.

[1] High-risk pool is for HIPAA-eligibles only.
[2] Blue Cross/Blue Shield is required to have a six month open-enrollment period.
[3] Florida's high-risk pool has been closed to new enrollment since 1991.
[4] Kaiser and other large insurers guarantee issue.
[5] Individual market insurers must make available four standardized health plans to high-risk applicants which are integrated into a statewide reinsurance pool.
[6] Insurers required to issue a basic and standard plan to those with 12 months prior coverage.
[7] HMOs must have a semiannual open-enrollment period.
[8] In 2001, the New Hampshire Legislature passed a series of reforms to the individual insurance market. As of July 1, 2002, insurers in New Hampshire will be allowed to deny coverage due to health status and to modify rates according to age and health status. The state will also begin operating a high-risk pool.
[9] Annual open-enrollment period with state-approved enrollment caps.
[10] Utah has standard underwriting guidelines. If someone is not classified as high-risk by these guidelines, insurers are required to sell to them. High-risk individuals are eligible for the state's high-risk pool.
[11] Insurers must sell to everyone except the sickest 8 percent of the state's individual market consumer. The excluded population can enroll in the state high-risk pool.
[12] HMOs selling individual policies are required to have an open-enrollment period.

Sources: Health Insurance Regulation Database supported by the Academy for Health Services Research and Health Policy, 2001; and "Summary Comparison of Individual Market Reform," Georgetown University Consumer Healthcare Education Project.

APPENDIX. STATE HIGH-RISK POOL WEBSITES

Alaska Comprehensive Health Association: www.achia.com

California Major Risk Medical Insurance Program:
www.mrmib.ca.gov/MRMIB/MRMIP.html

Colorado Uninsurable Health Insurance Plan: www.cuhip.com

Illinois Comprehensive Health Insurance Plan: www.state.il.us/ins/chip.htm

Indiana Comprehensive Health Insurance Association: www.onlinehealthplan.com/oasys

Iowa Comprehensive Health Association: www.onlinehealthplan.com/oasys

Kentucky Access: www.onlinehealthplan.com/oasys/kentucky/index.cfm?ti=0

Louisiana Health Insurance Association: www.lhia.org

Mississippi Comprehensive Health Insurance Pool: www.doi.state.ms.us/mchirpa.html

Missouri Health Insurance Pool:
www.insurance.state.mo.us/consumer/info/healthpool.pdf

Nebraska Comprehensive Health Insurance Plan: www.bcbsne.com/mainfram.htm

Comprehensive Health Association of North Dakota: www.chand.org

Oregon Medical Insurance Pool: www.cbs.state.or.us/external/omip/index.html

TennCare: www.state.tn.us/tenncare

Washington State Health Insurance Pool: www.onlinehealthplan.com/oasys

Wisconsin Health Insurance Risk Sharing Plan: www.dhfs.state.wi.us/hirsp/index.htm

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#449 *How the New Labor Market Is Squeezing Workforce Health Benefits* (June 2001). James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, Center for National Policy. To understand how labor market trends have contributed to the decline in the proportion of private-sector workers receiving benefits from their own employers—and to anticipate future trends—this study examines changes over a 19-year period, 1979 to 1998.

#464 *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children's Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

#453 *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured* (May 2001). Claudia L. Schur and Jacob Feldman, Project HOPE Center for Health Affairs. This report looks at factors that influence health insurance coverage for Hispanics, the fastest-growing minority population in the United States. The analysis shows that characteristics of

employment account for much, but not all, of the problem. Family structure seems to play some role, as does immigrant status, which affects Hispanic immigrants more than other groups.

Preparing for the Future: A 2020 Vision for American Health Care (April 2001). Karen Davis. *Academic Medicine,* vol. 76, no. 4. Copies are available from Karen Davis, President, The Commonwealth Fund, 1 East 75th Street, New York, NY 10021-2692.

#462 *Expanding Public Programs to Cover the Sick and Poor Uninsured* (March 2001). Karen Davis. In invited testimony before the Senate Finance Committee, the Fund's president presented a compelling case for expanding existing public health insurance programs to provide coverage for the most vulnerable segments of the nation's 42.6 million uninsured. She stressed the importance of expanding Medicaid and the Children's Health Insurance Program (CHIP) to cover parents of covered children.

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How a Changing Workforce Affects Employer-Sponsored Health Insurance (January/February 2001). Gregory Acs and Linda J. Blumberg. *Health Affairs,* vol. 20, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#425 *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

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Customizing Medicaid Managed Care—California Style (September/October 2000). Debra A. Draper and Marsha Gold. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

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Inadequate Health Insurance: Costs and Consequences (August 11, 2000). Karen Donelan, Catherine M. DesRoches, and Cathy Schoen. *Medscape General Medicine.* Available online at www.medscape.com/ Medscape/GeneralMedicine/journal/public/mgm.journal.html.